Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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130 Dufferin Avenue 4th floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2019	2019_778563_0038	017900-19, 018681-19	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Glendale Crossing
3030 Singleton Avenue LONDON ON N6L 0B6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 15, 16, 17 and 18, 2019

The following Complaint intake was completed within Critical Incident inspection #2019_778563_0039:
- Log #018681-19 for Complaint #IL-70619-LO related to staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the General Manager, the Acting Assistant Director of Nursing Care, the Neighbourhood Coordinators, Registered Practical Nurses, Personal Support Workers, family members and the resident.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) also observed the posting of the Residents' Bill of Rights and reviewed the Resident Handbook.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of the resident was fully respected and promoted: Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

The Ministry of Health and Long Term Care Complaint Information Report documented a reported complaint related to a violation of a resident's rights related to refused visitation by the resident's long time partner. The complainant stated they attempted to call the home to speak with the resident several times. This was so that the resident's partner could speak with the resident but were told by the home that the resident was either unavailable or that the resident did not live there.

The Advocacy Centre for the Elderly (ACE) addressed a letter to the complainant. The letter provided general information to the complainant about the law regarding restriction of visitors by long-term care homes, attorneys for personal care, substitute decision-makers and family members:
a) "Long-Term Care Homes Act: No authority to restrict visitors. First, homes have no authority to restrict visits. The Long-Term Care Homes Act (LTCHA) includes a Residents' Bill of Rights (LTCHA s. 3) which homes must comply with. Resident Right #14 states as follows: Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. Homes therefore have no authority to restrict anyone that a resident wishes to have visit from doing so. Homes may not prevent visitors, restrict visitors to times/places, issue "Trespass Notices", etc."

b) "Attorneys for Personal Care, Substitute Decision-Makers, Family Members: No authority to restrict visitors. In many cases, homes will restrict visitors after being instructed to do so by a family member, substitute decision-maker or attorney for personal care. In most cases, the person who is giving the instructions has no legal authority to do so."

c) "The Health Care Consent Act (HCCA) governs decisions related to:
(1) treatment by a health care professional;
(2) admission to a long-term care home; and
(3) personal assistance services in a long-term care home or retirement home.
The HCCA does not deal with any other type of decision-making, including "visitors".

d) "Substitute Decisions Act, if a person is an attorney under a power of attorney for personal care, the SDA authorizes them to make decisions in the following areas but ONLY if the person has been determined to be incapable of making that decision: health care, nutrition, shelter, clothing, hygiene or safety (SDA s. 45). Only if the decision relates to one of these areas AND the person has been found to be incapable of making a decision can the attorney make the decision on behalf of the person."

e) "In general, making a decision as to who can "visit" is NOT within the authority of the attorney for personal care, as it does not come within the six enumerated headings in the SDA. The only exception to this MAY be if it is a "safety" issue, for example, if there are allegations of abuse. However, this is very rare. It is also NOT within the authority of a substitute decision-maker under the HCCA as it is not treatment, placement or personal assistance services as defined in the legislation."

The resident stated they had a partner for many years and expressed their desire to call their partner but did not have access to a phone. The resident stated they got along well with their partner and it saddened the resident not being able to see their partner. The resident also stated they wanted to spend time with their partner as they did everything together and no longer see each other.

Inspectors observed the nursing office on the resident's neighbourhood where there was a posted alert and photograph of the resident's partner. The post stated, "Alert. This [person] is to not be on [the] neighbourhood. Please if you see [them] ask [them] to leave and call Registered Nurse (RN)." The alert had a photo of the resident's partner and their name in brackets. The Registered Practical Nurse (RPN) stated the resident's family said it was a picture of the resident's partner and they were not allowed to visit the resident. The RPN said they were working when the resident's partner called to talk to the resident, the partner said their name and the RPN told the partner that they would need to talk to the resident's family first before the resident could speak to them. The partner's family member called and said they were coming to visit and would take the resident out. Another RPN joined the conversation and stated the resident's family provided a code word and that indicated the caller could speak to the resident. The RPN also stated the family were deciding this on the resident's behalf, but the resident wanted to see their partner. The RPN then said the resident wanted to see their partner, asked about them every day, said the partner was a good dancer, missed them, and this was their companion who made them happy. The RPN shared the resident was in the nursing station at one time and saw the picture and read the alert about their partner and was

very angry, shouting that the partner was not a bad person, that they were good.

The General Manager (GM) stated the resident's partner and their family member were calling trying to contact the resident and they also sent a fax to the home about the Residents' Bill of Rights. The GM then reached out to the resident's POA to find out who those people were and the POA stated the family did not want them to take the resident out and wanted the resident to adjust to the home. The GM stated the POA was in contact with the police to ask about what they could do. There was no formal trespassing order against the resident's partner, but the staff were to call the police if they saw the resident's partner and that was what the resident's POA asked the home to do. At that time, the home set up a password for family members so staff could know who could and could not visit the resident. The GM acknowledged they did not know the full story and were not given any further information, but the POAs were concerned the resident's partner would come and take the resident out, go back home and not return. The GM verified the POA provided a picture of the resident's partner and it was posted on the back porch (nursing office) to let everyone know. The GM was asked if the resident received phone calls from friends and family and the GM stated as long as they have the password. The GM stated the resident's partner and the partner's family were not to contact or see the resident on or off the neighbourhood. The GM stated there had been no further attempts to contact the resident by their partner or the partner's family. The GM verified the home did not fully respect and promote the resident's right to communicate in confidence, receive visitors of their own choice and consult in private without interference and stated no one spoke to the resident about their preferences for visitors. Registered staff reported the resident asked the nursing staff about their partner every day, and every day the resident wanted to see or speak to them. The staff reported the resident only spoke very highly of the partner and the resident was upset when they saw the picture and alert in the nursing office. The resident was trying to convince the staff that their partner was a good person and the resident had been told they were not allowed to see or talk to them. The GM acknowledged this would be stressful for the resident and posed a risk to the resident's emotional health.

The GM shared the home had removed the alert posting and picture related to the resident's partner, educated the team and contacted the POAs. The GM shared that the Residents' Bill of Rights was posted between the main doors at the front of the home and this was observed. As well, the Residents' Bill of Rights was also included in the Resident Handbook which was provided to the resident and the POA on admission to the home.

of Rights, including "14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference."

The licensee failed to ensure the resident had the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference. [s. 3. (1) 14.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 14th day of November, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2019_778563_0038
Log No. / No de registre :	017900-19, 018681-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 25, 2019
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Glendale Crossing 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Awde

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with s. 3 (1) 14 of the LTCHA.
Specifically, the licensee must:
a) Ensure the resident and any other resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
b) Ensure the resident has the opportunity to express their wishes related to visitors and those wishes are to be documented as part of their plan of care.
c) Ensure safe guards are in place for the resident and any other resident for any visitations in the home and when visitations take place outside of the home.
d) Ensure the nursing and management team are educated related specifically to the residents' right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

Grounds / Motifs :

1. The licensee has failed to ensure that the following rights of the resident was fully respected and promoted: Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

The Ministry of Health and Long Term Care Complaint Information Report

documented a reported complaint related to a violation of a resident's rights related to refused visitation by the resident's long time partner. The complainant stated they attempted to call the home to speak with the resident several times. This was so that the resident's partner could speak with the resident but were told by the home that the resident was either unavailable or that the resident did not live there.

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(3) personal assistance services in a long-term care home or retirement home.
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that decision: health care, nutrition, shelter, clothing, hygiene or safety (SDA s. 45). Only if the decision relates to one of these areas AND the person has been found to be incapable of making a decision can the attorney make the decision on behalf of the person."

e) "In general, making a decision as to who can "visit" is NOT within the authority of the attorney for personal care, as it does not come within the six enumerated headings in the SDA. The only exception to this MAY be if it is a "safety" issue, for example, if there are allegations of abuse. However, this is very rare. It is also NOT within the authority of a substitute decision-maker under the HCCA as it is not treatment, placement or personal assistance services as defined in the legislation."

The resident stated they had a partner for many years and expressed their desire to call their partner but did not have access to a phone. The resident stated they got along well with their partner and it saddened the resident not being able to see their partner. The resident also stated they wanted to spend time with their partner as they did everything together and no longer see each other.

Inspectors observed the nursing office on the resident's neighbourhood where there was a posted alert and photograph of the resident's partner. The post stated, "Alert. This [person] is to not be on [the] neighbourhood. Please if you see [them] ask [them] to leave and call Registered Nurse (RN)." The alert had a photo of the resident's partner and their name in brackets. The Registered Practical Nurse (RPN) stated the resident's family said it was a picture of the resident's partner and they were not allowed to visit the resident. The RPN said they were working when the resident's partner called to talk to the resident, the partner said their name and the RPN told the partner that they would need to talk to the resident's family first before the resident could speak to them. The partner's family member called and said they were coming to visit and would take the resident out. Another RPN joined the conversation and stated the resident's family provided a code word and that indicated the caller could speak to the resident. The RPN also stated the family were deciding this on the resident's behalf, but the resident wanted to see their partner. The RPN then said the resident wanted to see their partner, asked about them every day, said the partner was a good dancer, missed them, and this was their companion who

made them happy. The RPN shared the resident was in the nursing station at one time and saw the picture and read the alert about their partner and was very angry, shouting that the partner was not a bad person, that they were good.

The General Manager (GM) stated the resident's partner and their family member were calling trying to contact the resident and they also sent a fax to the home about the Residents' Bill of Rights. The GM then reached out to the resident's POA to find out who those people were and the POA stated the family did not want them to take the resident out and wanted the resident to adjust to the home. The GM stated the POA was in contact with the police to ask about what they could do. There was no formal trespassing order against the resident's partner, but the staff were to call the police if they saw the resident's partner and that was what the resident's POA asked the home to do. At that time, the home set up a password for family members so staff could know who could and could not visit the resident. The GM acknowledged they did not know the full story and were not given any further information, but the POAs were concerned the resident's partner would come and take the resident out, go back home and not return. The GM verified the POA provided a picture of the resident's partner and it was posted on the back porch (nursing office) to let everyone know. The GM was asked if the resident received phone calls from friends and family and the GM stated as long as they have the password. The GM stated the resident's partner and the partner's family were not to contact or see the resident on or off the neighbourhood. The GM stated there had been no further attempts to contact the resident by their partner or the partner's family. The GM verified the home did not fully respect and promote the resident's right to communicate in confidence, receive visitors of their own choice and consult in private without interference and stated no one spoke to the resident about their preferences for visitors. Registered staff reported the resident asked the nursing staff about their partner every day, and every day the resident wanted to see or speak to them. The staff reported the resident only spoke very highly of the partner and the resident was upset when they saw the picture and alert in the nursing office. The resident was trying to convince the staff that their partner was a good person and the resident had been told they were not allowed to see or talk to them. The GM acknowledged this would be stressful for the resident and posed a risk to the resident's emotional health.

The GM shared the home had removed the alert posting and picture related to

the resident's partner, educated the team and contacted the POAs. The GM shared that the Residents' Bill of Rights was posted between the main doors at the front of the home and this was observed. As well, the Residents' Bill of Rights was also included in the Resident Handbook which was provided to the resident and the POA on admission to the home.

The Schlegel Villages Long Term Care Resident Handbook outlined the 27 Resident Bills of Rights, including "14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference."

The licensee failed to ensure the resident had the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was isolated to one resident. The home had a level 2 history as the home had one or more non-compliance (s), none of which were the same subsection being cited, with this section of the Long Term Care Homes Act. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

Service Area Office /
Bureau régional de services : London Service Area Office